STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
SOUTHEAST REGION

Human Resources
1010 W. Columbia
Farmington, MO 63640

EMPLOYMENT APPLICATION

Southeast Missouri Mental Health Center (SMMHC)

Please check one or both

☐ *Adult Psychiatric Services (APS)*

☐ *Sex Offender Rehabilitation Treatment Services (SORTS)*

NAME (LAST)	(FIRST)	(MIDDLE)	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE	COUNTY

TELEPHONE NUMBER	ALTERNATE/CELL NUMBER	HAVE YOU WORKED UNDER ANY OTHER NAME? ☐ Yes ☐ No IF YES, WHAT NAME(S)? _____	MAIDEN NAME

FOR WHAT POSITION(S) ARE YOU APPLYING? _____

HOW DID YOU LEARN ABOUT THIS POSITION? ☐ Newspaper ☐ Division of Family Services ☐ Family/Friend ☐ Job Service ☐ Just walked in ☐ Other _____

FOR WHAT TYPE OF EMPLOYMENT ARE YOU APPLYING? ☐ FULL TIME ☐ PART TIME ☐ TEMPORARY ☐ ANY

WHAT IS THE MINIMUM SALARY YOU WILL ACCEPT? _____

STATE LAW PROHIBITS THE HIRING OF RELATIVES IN CERTAIN SITUATIONS. DO YOU HAVE ANY RELATIVES (SPOUSE, CHILD, PARENT, SIBLING, GRANDPARENT OR GRANDCHILD) WORKING FOR THE DEPARTMENT OF MENTAL HEALTH? ☐ Yes ☐ No IF YES, STATE DETAILS _____

HAVE YOU EVER BEEN EMPLOYED BY SOUTHEAST MISSOURI MENTAL HEALTH CENTER (ADULT PSYCHIATRIC SERVICES), SEX OFFENDER REHBILITATION TREATMENT SERVICES (SORTS), OR ANY OTHER STATE OF MISSOURI AGENCY? ☐ Yes ☐ No IF YES, PLEASE STATE AGENCY NAME, JOB TITLE AND DATES OF EMPLOYMENT_____

_____

HAVE YOU EVER BEEN CONVICTED OF, PLED GUILTY OR NOLO CONTENDERE TO, ANY CRIME OTHER THAN A MINOR TRAFFIC VIOLATION, INCLUDING ANY SUSPENDED IMPOSITION OR EXECUTION OF SENTENCE; OR HAVE YOU SERVED ANY PERIODS OF PAROLE OR PROBATION? ☐ Yes ☐ No IF YES, STATE DETAILS _____

_____

HAVE YOU EVER BEEN FOUND TO HAVE ABUSED OR NEGLECTED ELDERLY OR HANDICAPPED PATIENTS OR RESIDENTS, OR HAVE YOU BEEN PLACED ON THE EMPLOYEE DISQUALIFICATION LIST OF THE DIVISION OF AGING? ☐ Yes ☐ No

TO YOUR KNOWLEDGE, DO YOU HAVE ANY RELATIVES OR FRIENDS CURRENTLY OR POTENTIALLY RECEVING SERVICES AT THE SEX OFFENDER REHABILITATION TREATMENT SERVICES (SORTS), THE CORRECTIONAL TREATMENT CENTER AND /OR THE FORENSIC PROGRAM AT ADULT PSYCHIATRIC SERVICES (APS)? ☐ Yes ☐ No *IF YES, THIS WILL BE DISCUSSED CONFIDENTIALLY WITH THE INTERVIEWER.*

RECORD OF EDUCATION

HAVE YOU GRADUATED FROM HIGH SCHOOL OR OBTAINED A GED?	☐ YES ☐ NO
ARE YOU CURRENTLY ATTENDING SCHOOL/COLLEGE?	☐ YES ☐ NO

LIST COLLEGE, UNIVERSITY OR VOCATIONAL SCHOOL BELOW

NAME AND LOCATION	DATES OF ATTENDANCE	COURSE OF STUDY	SEMESTER HOURS OR CLOCK HOURS COMPLETED	LIST DIPLOMA OR DEGREE ATTAINED
NAME				
LOCATION				
NAME				
LOCATION				

RECORD OF EMPLOYMENT/MILITARY SERVICE
(Begin with current or most recent employer)
(Attach additional sheets if necessary. Resume may be used if ALL information is available.)

NAME AND ADDRESS OF EMPLOYER	FROM		TO		HOURS PER WEEK	POSITION HELD AND DUTIES	
	MONTH	YEAR	MONTH	YEAR			
							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING
							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING
							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING
							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING
							NAME OF SUPERVISOR
							TELEPHONE
							REASON FOR LEAVING

MAY WE CONTACT YOUR PRESENT EMPLOYER(S)? ☐ Yes ☐ No IF YES, YOUR SIGNATURE BELOW AUTHORIZES ANY FORMER OR PRESENT EMPLOYER TO FURNISH THE DEPARTMENT OF MENTAL HEALTH WITH ANY AND ALL INFORMATION CONCERNING YOUR PREVIOUS EMPLOYMENT AND RELEASES ANY FORMER OR CURRENT EMPLOYER FROM ALL LIABILITY FOR AND DAMAGES IN FURNISHING SUCH INFORMATION. IF NO, ONLY FORMER EMPLOYERS WOULD BE CONTACTED AND YOUR SIGNATURE BELOW PROVIDES AUTHORIZATION AND RELEASES FROM LIABILITY AS INDICATED ABOVE.

IF YOU ARE CURRENTLY CERTIFIED, REGISTERED, OR LICENSED TO PRACTICE YOUR PROFESSION OR OCCUPATION,
GIVE NAME OF ASSOCIATION OR LICENSING AUTHORITY____
CERTIFICATION, REGISTRATION, OR LICENSING NUMBER____________________EXPIRATION DATE ______________
CERTIFIED, REGISTERED, OR LICENSED IN THE STATE OF MISSOURI? ☐ YES ☐ NO

IF LICENSED, HAS YOUR PROFESSIONAL LICENSE (EXCEPT FOR DRIVER'S LICENSE) EVER BEEN DISCIPLINED, SUSPENDED, REVOKED, REPRIMANDED, RESTRICTED, CURTAILED, OR VOLUNTARILY SURRENDERED, OR DO YOU HAVE ANY PENDING COMPLAINTS BEFORE ANY REGULATORY BOARD OR AGENCY, OR IS THERE ANY INVESTIGATION OR ADVERSE ACTION NOW PENDING AGAINST YOU? ☐ YES ☐NO IF YES, EXPLAIN ALL SUCH INCIDENTS, GIVING FACTS AND DATES, AND DESCRIBING ANY ACTION THAT YOU TOOK AND ANY RESOLUTION TO THE MATTER. (IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE SHEET.) ____

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SHOULD I BE EMPLOYED BY THIS FACILITY, I UNDERSTAND THAT I WILL BE REQUIRED TO FULFILL ALL ESSENTIAL FUNCTIONS OF THE JOB I AM HIRED TO PERFORM, WITH OR WITHOUT ACCOMODATION. INABILITY TO DO SO MAY RENDER ME NO LONGER QUALIFIED FOR THE POSITION, AND MAY BE CONSIDERED CAUSE FOR DISMISSAL.

A DRUG SCREEN WILL BE PERFORMED PRIOR TO EMPLOYMENT. EMPLOYMENT WILL BE CONTINGENT UPON NEGATIVE RESULTS.

I UNDERSTAND THAT THE DEPARTMENT OF MENTAL HEALTH PARTICIPATES IN RANDOM DRUG SCREEN AND RANDOM BACKGROUND SCREENINGS OF EMPLOYEES AND THAT CONTINUED EMPLOYMENT WILL BE CONTINGENT UPON THE RESULTS OF THESE SCREENINGS.

I UNDERSTAND THAT SOUTHEAST MISSOURI MENTAL HEALTH CENTER PROMOTES A DRUG FREE WORK PLACE AND AGREE TO TESTING AS THE FACILITIES DEEM NECESSARY.

I UNDERSTAND THAT SOUTHEAST MISSOURI MENTAL HEALTH CENTER IS A TOBACCO FREE ENVIRONMENT WHICH PROHIBITS THE USE/POSSESSION OF ALL TOBACCO PRODUCTS ON GROUNDS, BUILDINGS, AND PARKING LOTS. I AGREE TO COMPLY WITH THE SOUTHEAST REGION POLICY, R-LD.190 – SMOKE/TOBACCO FREE CAMPUS.

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND THAT ANY FALSIFICATION OR MISREPRESENTATION MAY RESULT IN MY DISMISSAL AT ANY TIME THEREAFTER SHOULD I BE EMPLOYED BY THE STATE OF MISSOURI.

SIGNATURE	DATE